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TODD & BOWMAN'S PHYSIOLOGY,

TWENTY-FOUR PAGES.

CLINICS.

Clinical Lecture on Permanent Contraction of the Fingers. By Prof. VELPEAU.

Gentlemen,—Permanent flexion or contraction of the fingers depends on a great number of causes; it may arise from wounds, paralysis of the extensor muscles, ankylosis of the joints, tumours, shortening of the tendons, irregular cicatrices, &c. On the present occasion, however, I wish to direct your notice to that form which depends on contraction of the palmar fascia, or on the formation of fibrous bands extending from the palm of the hand to the fingers, and binding down the latter in their irregular position.

Before the remarks published in 1831, by Dupuytren, followed up by those of MM. Lemoine, Mandet, Vidal, Goyraud, &c., permanent contraction of the fingers had not been much noticed by surgeons. Boyer alludes to the affection under the name of *crispatura tendinum*; Sir Astley Cooper, also, speaks of permanent retraction of the fingers and toes, which he attributes to con-

traction of the sheaths of the tendons or of the palmar and plantar aponeuroses. Dupuytren has clearly shown that the tendons are seldom engaged in this affection, but he has not so evidently demonstrated that it depends on induration, or shortening of one or more bands of the palmar fascia.

The disease now under consideration is characterized by the formation of certain bands or chords, which are elevated beneath the skin, and extend along a considerable portion of the palmar surface of the finger; these bands generally occupy the median line, and are attached usually to the first phalanx, but sometimes prolonged to the second or third. According to Dupuytren, this disease generally begins on the ring finger, and thence extends to the little finger; it increases gradually, without occasioning pain; the patient, at first, experiences a feeling of stiffness in the palm of the hand, and is unable to extend one or more fingers; the latter soon become contracted, and in extreme cases, the tip of the finger rests on the palm of the hand. On examination, the first thing which we notice is a

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chord extending along the palm and finger: if you attempt to straighten the finger, this chord becomes more tense, and it disappears when you flex the finger completely; it is rounded off in shape, and forms a kind of bridge or prominence at the metacarpo-phalangeal joint. The skin is wrinkled into arched folds, extending from the middle of the palm of the hand to the base of the finger. The disease, thus progressing, may attain its maximum degree of severity without causing any pain, or appearance of ankylosis; the joints are easily flexed, but cannot be extended by the most powerful efforts; Dupuytren has seen 150 pounds weight suspended on the bent finger, without producing any effect on it.

This retraction of the fingers is a very disagreeable affection; it prevents the patient from seizing any large body, and when he closes the fingers strongly, severe pain is felt. Persons labouring under permanent contraction of the fingers, are usually those who have made violent efforts with the palm of the hand, or been employed in occupations during which the palm and fingers are frequently pressed against hard bodies. Thus, it is met with amongst masons, ploughmen, watermen, coachmen, &c.—Dupuytren mentions the case of a literary personage who was attacked in consequence of frequently using a round-handled office-seal for his letters.

What is the anatomical lesion which characterizes permanent contraction of the fingers? Upon this point there exists a variety of opinions. Some attribute it to thickening and contraction of the skin; others to spasm of the muscles; disease of the flexor tendons; inflammation and contraction of the sheaths of the tendons; some change in the joints and their lateral ligaments; finally, contraction of the palmar fascia. This latter idea was chiefly supported by Dupuytren and Sir Astley Cooper; the following case was the one which influenced Dupuytren's opinion:—An old man, who had been affected for many years with retraction of the fingers, died in the Hôtel-Dieu; Dupuytren examined the parts with great care; on removing the skin from the palm of the hand it was found that the folds of integument completely disappeared; the palmar fascia was contracted and shortened, and several bands passed from its lower part to the sides of the deformed finger. On endeavouring to extend the fingers, Dupuytren perceived that

the fascia and these bands were rendered more tense; he divided the bands, and effected, at once, complete extension of the contracted fingers; the tendons and their sheaths had not been touched; the joints likewise and bones were completely free from any appearance of alteration. From this case Dupuytren naturally concluded that the disease originated in abnormal tension of the palmar fascia, a tension depending on contraction excited by the pressure of some hard substance on the palm of the hand. The case certainly shows that contraction of the fingers may sometimes depend on a change in the palmar fascia, but it does not prove that this is always the cause. The bands or hard chords which, as I have already mentioned to you, are seen projecting under the skin, extend to the palmar surface of the first phalanx, and sometimes to the second or third phalanx. Now we know that the palmar fascia terminates at the root of the finger, by becoming attached to the sheaths of the tendons and ligaments; besides, the fascia does not cover the ball of the thumb or extend to its root, yet we have permanent contraction of the thumb, with the subcutaneous chords already noticed. Having determined, by dissection, that the palmar fascia remained sometimes intact, after the removal of these chords, I announced, in 1833, that the prolongations mentioned by Dupuytren were not always formed by the palmar fascia; but that they seemed to me to depend on transformation of the subcutaneous cellular tissue into fibrous bands. M. Goyraud, surgeon to the Hôtel-Dieu of Aix, has proved the correctness of this opinion by his researches on permanent contraction of the finger, published in the third volume of the *Memoirs of the Royal Academy of Medicine*. In addition to a carefully performed dissection, M. Goyraud relates the following case, which confirms my view of the nature of this disease.

“M. Chaine, steward of the hospital, presents a remarkable example of the permanent contraction of the fingers. The three last fingers of the right hand are flexed; of the left, the four last fingers are in the same condition. The left ring finger is more flexed than the others; on the right side, the little finger is the one most contracted; the middle fingers are only semi-flexed. The contraction came on gradually, and without any pain. M. Chaine is now 58 years of

age; when at the age of 42, he first perceived that he was unable to extend the left ring-finger completely. The latter became gradually contracted, and the affection soon extended to the two neighbouring fingers. Shortly afterwards, the right little finger began to contract, and then the ring and middle fingers of the same hand. The first phalanges are now flexed at a right angle on the metacarpal bones, and the second phalanges at various angles on the first. On attempting to extend the fingers, it is evident that they are retained in the flexed position by a number of bands running from the palmar fascia to the middle part of the fingers."

In this case, the disease consists in flexion of the first phalanx on the metacarpal bone, and of the second phalanx on the first; the joints of the third phalanges are completely free.

Hence, since contraction of the palmar fascia and its digital prolongations could only influence the first phalanx, it is evident that the contraction of the second phalanx must depend on some other cause. Even in the lectures of Dupuytren, we may find a proof of this. M. L. had contraction of the ring and little fingers of the left hand, which were completely flexed on the palm; the second phalanx was bent on the first, and the tip of the third applied to the ulnar edge of the palm; the little finger was constantly flexed on the palm of the hand also. Mr. Dupuytren operated in the following manner:—He commenced by making a transverse incision, ten lines in length, opposite the metacarpo-phalangeal joint of the ring-finger; the knife divided first the skin, and then the palmar fascia. The ring-finger was now reduced nearly to its natural position.

Being desirous of sparing the pain of a second incision, Dupuytren endeavoured to prolong the incision of the palmar fascia, towards the ulnar edge of the hand, but could not succeed; he was therefore compelled to make a second transverse incision opposite the articulation between the first and second phalanx of the little finger, and thus separated its point from the palm, but the remainder of the finger was still immovable. A third incision divided the skin and fascia, opposite the metacarpo-phalangeal joint of the little finger; the benefit was very slight, and he was forced to make an incision opposite the middle of the last phalanx, when the finger at once became

straight. Is it not clear, from this case, that other parts besides the palmar fascia were engaged in the disease? Do not we all know that the prolongations of this fascia are attached to the sides and not to the middle of the first phalanx?

From the facts which have been just mentioned, M. Goyraud concludes that permanent contraction of the fingers never depends on the palmar fascia; that we should avoid dividing this latter in any operation for the relief of the disease, and that Dupuytren, probably, divided the subcutaneous bands developed in the cellular tissue, and not prolongations from the palmar aponeurosis.

This opinion seems to me to be too exclusive, and I agree with M. Sanson in thinking that permanent contraction of the fingers may depend on the palmar fascia, on the skin, or more frequently on transformation of the cellular tissue into fibrous bands.

The treatment of this affection is exclusively surgical; we can expect no benefit from any other means than division of the fibrous bands by which the finger is retained in the flexed position. Dupuytren made an assistant extend the fingers as far as possible, and then divided the most tense part of the band; if the finger could now be straightened completely, the operation was finished; if not, he made one or more incisions above or below the first one. When the fingers became free, he maintained them in the extended position by means of bandages and splints, for a month or six weeks; but as soon as the state of the wound permitted, he commenced movements of flexion and extension.

M. Goyraud operates in a different way: he makes his incision along the side of the band, and in the same direction with it, and then divides the band in various places, or excises a portion of it. This method has many advantages over that of Dupuytren; the patient runs less risk of inflammation extending along the sheaths of the tendons, or palm of the hand; it allows us to commence moving the fingers at an earlier period, and leaves a much smaller cicatrix. When we have restored the finger to its natural position by means of operation, we are not to think that the patient is free from the danger of relapse. Considerable care must be bestowed on the after-treatment; the joints must be frequently moved; dis- cutient lotions, &c., applied, and the patient must be particularly cautioned against using

any hard bodies, or employing himself in any occupation by which the palm of the hand may be irritated.—*Prov. Med. and Surg. Journ.*

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Child with a Tail.—Dr. J. D. PLUNKETT, of Shelby Co., Tenn., writes to us that he "was requested to visit a female infant, six months old, from the extremity of whose coccyx there issued something much resembling a tail, four inches long, gradually tapering, and the small end adherent to the middle of the thigh. Finding that it contained neither bone nor cartilage, I removed it by applying a ligature to each end of the loop."

Remittent Fever—Bronze Liver.—Dr. MOSES stated to the New York Pathological Society, that there had been in the New York Hospital a case of pure southern remittent fever, in a seaman who, arriving perfectly well after an eight days passage, was immediately attacked with (congestive) remittent fever, and was comatose when brought into the hospital. The *liver* presented one of the finest specimens he had ever seen of the "Bronze Liver," described by Dr. Stewardson, of Philadelphia, in his paper in the *American Journal of the Medical Sciences*. It was enlarged, softened, and its internal structure had a deep olive tinge. The *spleen* was four times its natural size, and remarkably soft and diffluent. There was excessive congestion of the *vena portae* and *cava*, and more or less of the veins of the brain. There had been, during life, intense burning heat of the epigastrium; the tongue was moist, soft and white; uneasiness about the stomach and constant vomiting, like that from corrosive poison, for some hours before death. The *stomach* was slightly injected. The bile in the gall-bladder dark as molasses, and very thick and tenacious.—*The Annalist*, Oct., 1846.

National Medical Convention.—At the meeting of the Ohio Medical Convention, held at Columbus, May 12th, 1846, Prof. M. B. Wright, of the Medical College of Ohio, Prof. Samuel St. John, of the Medical College at Cleveland, and Prof. John Butterfield, of the Medical College at Willoughby, were appointed delegates to represent

that convention in the National Convention, to assemble in Philadelphia in May, 1847.

University of Pennsylvania.—From the Report of the Medical Department of this institution, it appears that at the commencement in July last, the degree of M. D. was conferred on seven candidates, making the whole number of graduates during the year 171.

Medical Department of the Army.—The Army Medical Board, lately in session in the city of New York, has recommended the following persons for appointment to the Medical Staff of the Army:

Robert Newton,	Pennsylvania.
Horace R. Wirtz,	Do.
Israel Moses,	New York.
John F. Hammond,	South Carolina.
Josephus M. Steiner,	Ohio.
Robert C. Wickam,	Virginia.
Charles P. Dyerle,	Do.
Elisha J. Bailey,	Pennsylvania.

FOREIGN INTELLIGENCE.

Uterine Disease during Pregnancy.—The history of the influence of fibrous bodies and of polypi on the progress of pregnancy, and on the function of parturition, has been the object of Dr. FORGET's researches. With regard to fibrous productions, their danger may be considered to be in proportion to their size and to their number: when their volume is small, they do not materially interfere with the functions of the gravid uterus, nor prevent its retraction after accouchement; the same innocuity will be observed when the fibrous bodies lie under the peritoneum, by which they are alone attached to the womb. These fortunate circumstances are not, however, always met with, and when situated in the uterine walls, they often become a cause of abortion, and always render labour difficult, and may produce fatal hemorrhage. During the last stage of pregnancy the increased phenomena of nutrition, occasioned in the uterus by the development of the *fœtus*, explain the rapid growth of the tumours, and the consequent severity of accouchement. As to polypi, M. Forget considers as a demonstrated fact that polypi, even very large, situated in the womb or in the vagina, do not prevent impregnation, and cause but little uneasiness during pregnancy: they seldom produce abortion. When the polypus remains in the womb after delivery,

the danger is great for the mother; but it is the life of the child that is endangered when the polypus has descended into the vagina. In the latter case the surgeon should not operate until the womb has resumed its natural dimensions; but when the tumour occupies the uterine cavity, and abundant hemorrhage is present, surgical art must interfere for its removal.—*Med. Times*, Sept. 12. 1846.

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Two ounces of Nitrate of Potash taken at once.—Mr. GILLARD communicated to the S. W. branch of the Prov. Med. and Surg. Association, an account of a case in which two ounces of nitrate of potash were taken by a man in mistake for epsom salts. Five minutes after taking it a burning pain in the stomach was felt, which was followed by sickness. The mistake was then discovered. A mustard emetic was administered, followed by carbonate of magnesia and opium. Under this treatment the patient speedily recovered.

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Unsuspected Dislocation of the Femur.—R. WELSH, Esq., records in the *Prov. Med. and Surg. Journal*, the following case as a warning to his surgical brethren, and to induce them to make a strict examination into every case of accident, however trifling it may at first appear. A man, aged 28, was partially buried by a bank of earth falling on him whilst he was undermining it. Mr. W. saw him a few hours after the accident; his only complaint was of slight pain in the back and knee; but as there appeared no distortion of the limb as it lay flexed upon the other, and flexion and extension were not much impeded, Mr. W. considered it a mere bruise, and treated it accordingly. At the end of a fortnight Mr. W. saw him again; his report of himself was, that he was much better, had been up, and said, that with a strengthening plaster he should be quite well. Anxious to see how he could walk, Mr. W. made him get up, when at once the nature of the accident was too evident—namely, dislocation of the femur on the dorsum ilii. The necessary measures for reduction of the dislocation were then resorted to, and with success.

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Hysteria.—Dr. GENDRIN, in a letter addressed to the President of the French Acad. of Medicine, brings forward the following opinions on the nature, symptoms, and treatment of hysteria:—1. Hysteria does not merely consist in intermittent spasmodic at-

tacks: it is a continuous malady which presents always characteristic symptoms in the intervals of the convulsive fits. 2. In all cases, without exception, from the beginning of the disorder to its termination, a general or partial loss of sensation may be observed; when the disease is mild in its form, anesthesia occupies only limited regions of the skin; when it is severe, on the contrary, it occupies the entire cutaneous surface, and the mucous membranes accessible to our means of exploration, such as the conjunctiva, the pituitary surface, the buccal mucous membrane, the rectum, urethra, vagina, and urinary bladder. It is not very uncommon to meet with this anesthesia in the organs of special sensation, and in deep-seated parts. Some patients lose the consciousness of the acts of locomotion and of the position of their limbs. 3. The degrees of anesthesia and of the violence of the fits do not bear any proportion to each other. 4. Most patients thus affected present in various regions, at least during the presence of the convulsive fits, a degree of pain, which is in general the proximate cause of the attack, and which furnishes the physician with a valuable practical indication. 5. In hysteria, paralysis, with flaccidity or contraction of the affected part, is a very frequent symptom which has often caused error of diagnosis, and which may last without peril for months, even when it occupies the bladder, rectum, or limbs. 6. It is a mistake to consider the sensation of the *globus hystericus* and asthma as phenomena constantly attendant upon hysteria. Two other forms of attack are very common or alternate with dyspncea; Dr. Gendrin refers to paroxysms of ecstasy or mania. 7. All the apparently marvelous peculiarities of animal magnetism may be spontaneously produced in hysteria. Thus, the insensibility which permits operations to be performed without pain exists in all the forms of the disease. In ecstatic hysteria it is observed in its highest degree. 8. The anomalies of enervation in hysterical subjects show themselves in the immediate action of medicines. Thus, patients who have no increased excitement of the digestive organs can take 12, 15, or 20 grains of opium without experiencing any narcotic results. If the stomach is in an irritated condition, the opium is rejected and no narcotism is observed. A few cases, not sufficiently numerous, however, to permit Dr. Gendrin to draw from them any positive

conclusions, lead him to believe that in hysteria large doses of hyoscyamus and of belladonna may be exhibited with impunity. 9. The most efficient drug in the treatment of hysteria is opium. The doses should be at first 6 grains daily, and be carried to 10 or 15 grains in the 24 hours. When a narcotic effect has been obtained, all the hysterical symptoms are observed to decrease, and the medicine should undergo a daily diminution. 10 Sulphuric ether, in doses of $\frac{3}{2}$ ss, $\frac{3}{2}$ vj, or $\frac{3}{2}$ j daily, is also very useful; but its beneficial action is not produced unless the patient takes these enormous quantities; no accident ever results from them.—*Medical Times*, Sept. 12, 1846.

Digestion in 1846.—At last the phenomena of digestion are enlightened: digestion is no more to be considered a simple but a complex function. There are as many digestions as organs. First, the stomach, by which animal food is dissolved; it is in carnivorous animals almost the only intestine, and they require no other; their digestion is gastric; it is intestinal in herbivorous tribes. After the incisors and cuspidati come the molares: in the same manner after the carnivorous intestine we find the intestines which digest grains and vegetables masticated by the molares. In the small intestine, feculent substances are absorbed and saccharified—a fact proved by a simple experiment; fecula taken in the stomach immediately above the pylorus will become blue when placed in contact with iodine, and will, on the contrary, not change colour after its passage through the pyloric orifice. It is this, the principal phenomenon of digestion in the duodenum, which has led to the discovery of the saccharifying power of the pancreatic secretion. Hence not only a change in the theory of digestion, but in the pathology of diabetes; we can no longer admit that the kidneys secrete sugar, but that they allow the passage of the saccharine matter contained in the blood.

All these discoveries are in themselves important scientific acquisitions; but their importance is doubled when their practical consequences are reflected upon. The whole history of gastralgia, *rudis indigestaque moles*, must begin anew. No theories can be compared to the recent discovery of the following facts. Eat meat, the urine becomes acid; eat vegetables, it immediately becomes alkaline.

The gastric juice is a powerful acid which readily gives birth by fermentation to gaseous products. In dyspepsia it is therefore a mistaken practice to recommend the use of alkaline salts, by which the digestion of animal food is retarded. The corrosive nature of the fluid accounts for gastric pain, pyrosis, &c., most probably the result of its contact with dry portions of the mucous membranes. By fermentation in the stomach, foul breath and flatulency will be produced; alkaline medicines will be of no avail, but mild laxatives are fully indicated. The digestive power of the gastric juice varies with its heat: below 10 deg. and above 35 deg., that power diminishes, and is completely lost beyond 50 deg. It is therefore not proper to eat very hot substances.

The stomach being the organ in which animal food is dissolved, meat should not be given in gastric affections; whereas feculent substances, digested in the jejunum, can be safely permitted.—*Ibid.*, from *Journ. de Méd.*

Subnitrate of Bismuth in Gastralgia.—Dr. BERTINI, of Turin, has lately employed this medicine in numerous cases of gastralgia, beginning with a dose of five centigrammes (= 0.77 grains), and gradually raising it to twenty centigrammes (= 3.08 grains.) It was mixed with calcined magnesia, and given three or four times a day. In most instances the neuralgic pains disappeared under the use of this medicine; and in cases where the gastralgia appeared to be connected with organic disease, the symptoms were always much alleviated.—*Lond. Med. Gaz.*, Sept., 1846.

Poisoning by Lead-shot left in a bottle.—An individual was seized with violent colic and symptoms of poisoning, after having drunk several glasses of liquor. Dr. HOHL, who was called to the patient, examined the liquid, and found it to be turbid instead of clear: and on pouring it out into a glass, he discovered at the bottom of the bottle two pellets of shot which had become firmly fixed and converted by corrosion to carbonate of lead. On examining them, he found only a very small nucleus of metallic lead in the centre of each: so long as the liquor was clear, no ill effects had followed its use;—these had only occurred when the turbid portion, near the bottom of the bottle, had been taken. The liquor was proved to hold

suspended, a salt of lead, from which the symptoms of poisoning had undoubtedly arisen. This shows that great care should be used in cleansing bottles; and that a few shot left in them may give rise to all the symptoms of lead-poisoning.—*Ibid.*

Cholera in Persia.—The last Levant packet which arrived at Malta brought the intelligence that the cholera had broken out in Persia, particularly at Teheran, where one of the brothers of the Schah has fallen. The Schah, with his court, had sought refuge in the mountains. It is feared that, as in 1832, this scourge may again visit Asia Minor and the Mediterranean.

The latest intelligence from Aden announces that the cholera had disappeared from that place, and that the troops were healthy.—*Ibid.*

Asiatic Cholera.—This disease, which made its appearance at Aden early in May, has, in consequence of the changing of the monsoon, nearly vanished, isolated cases occurring only at intervals. During the five days it raged, upwards of four hundred persons were carried off, the deaths being four out of five attacked; the cholera is, however, rapidly advancing along the territory of Yemen, and fears may be entertained of its appearance on the shores of the Mediterranean. The disease is making dreadful havoc in India.—*Med. Times*, July 18.

Cholera at Kurrachee.—The seaport of Kurrachee, formerly one of the healthiest military stations, has, ever since it became known to us, been visited triennially by cholera. In 1839, and again in 1842, the amount of suffering occasioned by it was terrible, yet slight compared to that which it has just endured. Between the 13th and 23d June, above 8000 human beings were cut off by it, including 895 Europeans, of whom 815 were fighting men, 595 sepoys; and, it is believed, about 7000 natives, besides camp-followers, and inhabitants of the town, have died. The pestilence had quitted Kurrachee, and was apparently creeping up the river. Fever of a very fatal kind had made its appearance amongst the European soldiers at Sukkur: its triennial visit is to be looked for next year. Her majesty's 17th had chiefly suffered: it was said they were to be moved down, while her majesty's 86th were to move up to Hydrabad.

An extremely dry season has been followed by an unusually wet one; between the 9th of June and the 17th of July upwards of thirty-five inches of rain fell.

The *Kurrachee Advertiser* states that 7000 of the inhabitants have been cut off by cholera—nearly 9000 victims in ten days' time.

"Of the 60th Rifles there died 4 sergeants, 101 men, 4 women, and 3 children. Total, 112.

"Of the 86th Regt.: 1 officer, 24 sergeants, 329 men, 17 women, and 16 children. Total, 387.

"Of the Company's Artillery: 4 sergeants, 19 men, 2 women, and 6 children. Total, 31.

"Of the 1st Bombay European Regt. (Fusiliers): 1 officer, 18 sergeants, 314 men, 9 women, and 23 children. Total, 365.

"Of the 3d N. I., 310 sepoys; of the 12th N. I., 236 sepoys; of the Belooch Batt., 49. Grand total, 1490; independent of the inhabitants."—*Naval and Military Gazette*.

Cholera in Holland.—This disease, under the mild form of what has been termed by the French *cholerine*, has made its appearance at Amsterdam and Rotterdam, and has already attacked a great number of individuals, but not one of the cases has proved fatal.—*Ibid.*, from *Gaz. Méd.*

Nitrate of Silver in Erysipelas.—M. JOBERT recommends the application of nitrate of silver in erysipelas, in the form of ointment rather than of the caustic itself. He gives three formulæ, of various strengths, for preparing this ointment. To 32 parts of lard, the strongest ointment has 12 parts of nitrate of silver, the next has 8 parts, whilst the weakest has only four.—*Gaz. des Hôp.*, Aug. 18, 1846, from *Ibid.*

Delirium Tremens in an Infant.—A little boy, five years of age, swallowed by mistake a large quantity of brandy. Vomiting speedily followed, and he passed a restless night, sleeping only toward morning. On awaking, it was observed that he had tremor of the hands, and that he could not hold a cup steadily. Convulsions with cramps ensued. The pulse was slow, the look timid, the pupil dilated, and the countenance pale.—Delirium supervened, and there was dysuria with great thirst. A cataplasm was applied to the abdomen, and calomel and jalap were

administered. The symptoms abated about the middle of the day; but towards evening there was a return of the tremor, with other nervous symptoms. An opiate was exhibited, from the effects of which the child slept soundly, and on awaking the whole of the symptoms had disappeared.—*Ibid.*

Ergot of Rye.—Dr. WRIGHT, in 1837, showed that the ethereal oil of ergot, in the dose of thirty drops, is as powerful as 3*j* of the powdered secale cornutum: in this Dr. PAROLLA fully agrees with Dr. Wright; but from the oil he has separated, by the assistance of alcohol, a resin which he conceives to be the real active principle of the drug, and which enjoys a powerfully sedative action. According to the author, this resin might replace most antiphlogistic measures; at doses of six to eight grains daily, he has found it efficient in pneumonia, typhus, and uterine hemorrhage. And so enthusiastic is Dr. Parolla in the cause of the resin that he conceives it to be capable of curing pulmonary consumption; a case of *complete cure*, he brought before the Scientific Congress at Florence, with the *anatomical preparation*: a proof of a rather unsatisfactory sort of recovery. Dr. Parolla states that the ergot is not a cryptogamic formation, but a morbid secretion of the diseased grain.—*Medical Times*, Sept. 19.

Ammonia as a Vesicant.—The following is the formula for making the ammoniacal pomade, which bears the name of Gondret. “In summer, take lard, 6 drachms; oil of sweet almonds, 2 drachms; tallow, 4 drs. Melt by a gentle heat, and pour into a wide-mouthed phial with a glass stopper. Then add 12 drachms of liquid ammonia at 27° or 28°; put in the stopper, and shake it up. It should be kept in a cool place; but as the temperature gets lower, put 2 drachms less tallow, and 2 more of lard. This pomade produces vesication in three, four, or five minutes.—*Lancet*, Sept. 12, 1846.

Military Flogging and its Effects.—An inquest was recently held at Hounslow, in the parish of Heston, Middlesex, on the 15th, 20th, and 27th of July, and the 3d of August inst., on the body of Frederick John White, aged twenty-seven years, a private in the 7th regiment of Hussars, who, in pursuance of a sentence of a District Court-martial, held at the Cavalry barracks, at Hounslow-

heath, on account of a sudden assault committed by him on a sergeant of the same regiment, received 150 lashes with a cat-of-nine-tails, administered by two regimental farriers, on the 15th of June last. Whilst undergoing this punishment, he was bound by the arms and legs to a ladder nailed to the wall. He suppressed any expression of pain, but asked for water during his flogging, which was given to him. On being untied, water was thrown on his shirt, which was replaced on him, and covered by his coat. He then walked to the hospital, of which he continued an inmate until his death on the 11th of July.—*Lancet*, Aug. 15th, 1846.

Cæsarean Operation.—Dr. KUNSEMULLER performed this operation on three females. Case 1 was that of a woman, aged 41, who had borne six children easily. The operation was performed at the end of the seventh pregnancy: the infant was taken out dead, and the woman died the day following. Case 2. A woman, aged 43, had had ten easy labours. Her pelvis deformed by osteomalacia, rendered the operation necessary in the eleventh pregnancy. The child was dead, and the woman died on the sixth day. Case 3. A woman, aged 38, had had five easy labours. She suffered much from want and disease, and her pelvis became deformed. On the sixth pregnancy, the antero-posterior diameter of the pelvis was found to have become smaller; but the child was extracted by the forceps. At the end of the seventh pregnancy, osteomalacia had advanced to a considerable extent. The Cæsarean operation was resorted to, and both mother and child were saved.—*Gaz. Méd.*

Wounds inflicted during Dissection.—M. BLATIN presented to the Medical Society of Emulation, (Paris) gloves, made of a thin sheet of caoutchouc, destined to guard the hand of the anatomist against injury from wounds during dissection, or from the contact of noxious substances in *post-mortem* examinations. The tissue of the gloves is so fine as not to interfere in any way with the movement of the fingers, and to diminish only in a very slight degree the sensation of the hand.—*Med. Times*, Sept. 12, 1846.

Obituary Record.—Died, on the 7th of Nov., Dr. FAVELL, of Sheffield, President of the Provincial Medical and Surgical Association.

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